2015 Joint Annual Report of Assisted-Care Living Facilities

Provisional Provisional

State ID:	000000	Facility Name:	-

TENNESSEE DEPARTMENT OF HEALTH
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JOINT ANNUAL REPORT OF
Assisted-Care Living Facilities
2015

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Schedule A - Identification

According to the Department of Health Rules and Regulations Section 1200-8-25.13(2), "The Joint Annual Report of Assisted Care Living Facilities shall be filed with the department. The forms… must be completed and returned to the department as required." Please read all information carefully before completing your Joint Annual Report with data for the year specified above. Please complete all items, using 0 (zero) when appropriate and checking all appropriate check boxes. Any items which appear to be inconsistent will be queried. **Facilities will be reported to the Board for Licensing Health Care Facilities for failure to timely file a complete report or respond to queries.**

Facility	State ID			
	License Number	-		
	ACLF Name	-		
	Did the facility's name change during the reporting period? Yes/No	-		
	If Yes, Prior Name			
	Street Address			
	City		County	
	State		Zip Code (5 digit)	
	Phone (10 digit)			
	Mailing Address same as Street Address? If Yes, proceed to next section. Yes/No	-		
	Mailing Address			
	City			
	State		Zip Code (5 digit)	
Preparer	Name		Phone	
	Title			
	E-Mail			
Reporting Period	If you are reporting for less than one full year, utilization and financial data should be presented for days reported only.			
	Is the reporting period from January 1 through December 31? Yes/No	-		
	If unable to report based on above dates, provide the beginning and ending dates (used for all utilization and financial data)		Beginning (mm/dd/yyyy)	
			Ending (mm/dd/yyyy)	
	Number of days in reporting period (System Calculated)			
Administration	Name of Administrator			
	Administrator Email Address			
	Name of Medical Director			

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Schedule B - Ownership of Business

Please select one item in each category that best describes your facility.

Type of Owner (select only one)	For Profit	-	(For Profit) Proprietorship – a business owned by one person.	
		-	(For Profit) Partnership – an association of two or more persons to carry on as co-owners of a business or other undertaking for profit formed under 61-1-202, predecessor law, or comparable law of another jurisdiction. TCA Title 61 Chapter 1.	
		-	(For Profit) Limited Partnership (LP) – a partnership formed by two or more persons under the law of the state of Tennessee, and having one or more general partners and one or more limited partners. TCA Title 61 Chapter 2.	
		-	(For Profit) Limited Liability Partnership (LLP) – is governed by TCA § 61-1-106(C). The law of this state governs relations among the partners and between the partners and the partnership and the liability of partners for an obligation of a limited liability partnership that has filed an application as a limited liability partnership in this state.	
		-	(For Profit) Limited Liability Company (LLC) – established by "The Tennessee Limited Liability Company Act" found in the TCA § 48-201-101 through § 48-248-606.	
		-	(For Profit) Corporation – defined by the Tennessee Business Corporation Act codified in TCA Title 48 Chapters 11-27.	
	Not For Profit	-	(Not For Profit) Non-Religious Corporation or Association – defined by "Tennessee Nonprofit Corporation Act" codified in TCA Title 48 Chapters 51-68.	
		-	(Not For Profit) Religious Corporation or Association – either a corporation or association that is organized and operated primarily or exclusively for religious purposes. Most of the provisions of the Tennessee Nonprofit Corporation Act apply to a religious corporation. Exceptions are specified in TCA § 48-67.	
		-	(Not For Profit) Limited Liability Company (LLC) – a company that is disregarded as an entity for federal income tax purposes, and whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in TCA § 67-4-1004(15).	
	Govern-ment	-	City	
		-	County	
		-	State	
		-	Federal	
		-	Other Government, specify	

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Schedule B - Ownership of Business

Owner and Business Information	Name of Owner (legal entity)						
	Yes/No	-	Chain	Name			
				Street			
				City			
				State		Zip Code	
	Yes/No	-	Holding Company/ Parent Corporation	Name			
				Street			
				City			
				State		Zip Code	
	Yes/No	-	Contract with Management Firm	Name			
				Street			
				City			
				State		Zip Code	

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Schedule C - Facilities and Services

Facilities	Yes/No	-	Did your facility have new construction and/or services during the year that resulted in a change of the facility's licensed bed count?	
			Cost of new construction	
Services	Yes/No	-	Does the facility operate an adult day care center? This program generally has minimal medical and social supervision for the older person who has help at home during the evening, but whose family or spouse is employed during the day. Services can include general assistance with the needs of daily living, socialization and lunches. In some instances, restorative and therapeutic programs may be included.	
	Yes/No	-	Does the facility provide respite care? This program provides overnight accommodations as well as some minimal medical and social supervision for older persons whose families may be temporarily unable to provide care for them.	
Alzheimer's Services	Yes/No	-	Does the facility have a specialized unit for Alzheimer's residents?	
			If yes, number of beds in that unit	
	Yes/No	-	If no, does the facility have specialized programs for Alzheimer's residents?	

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Schedule D - Beds

Licensed Beds	Number of beds licensed as of the last day of the reporting period. The number of licensed beds should equal the number of beds that you have been licensed to operate in the facility by the Tennessee Department of Health.					
	Yes/No	-	Did your facility have an increase in the number of licensed beds during the year? If yes, please provide the number of beds increased.			
			Date 1 (MM/DD/YYYY)		Number of Beds 1	
			Date 2 (MM/DD/YYYY)		Number of Beds 2	
	Yes/No	-	Did your facility have a decrease in the number of licensed beds during the year? If yes, please provide the number of beds decreased.			
			Date 1 (MM/DD/YYYY)		Number of Beds 1	
			Date 2 (MM/DD/YYYY)		Number of Beds 2	
Staffed Beds	If the full complement of licensed beds is not available for use or does not have staff available to provide care, the number of staffed beds will be less than the number of licensed beds. Number of beds set up and staffed on the last day of the reporting period.					
Bed Type	On the last day of the reporting period how many Staffed beds in your facility were in each of the following types?				Private beds	
					Semi-Private beds	

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Schedule E - Utilization

Admissions and Discharges	Admissions: all residents admitted to the facility during the reporting period	
	Discharges including Deaths: all residents discharged from the facility during the reporting period, including those who died during their stay	
	Deaths	
	Number of Discharge Days: the total number of days that each discharged resident stayed in the facility. Include days only for those residents who were discharged or died during the reporting period. This figure would include days for those residents who were admitted prior to or during the reporting period and were discharged during the reporting period (e.g., admitted 01/11 and discharged in the same year, on 6/30 = 171 days, the number of days that resident had been at the facility at the time of discharge; another resident admitted one year earlier on 1/11 and discharged on 6/30 the next year would be counted as 536 days). Do not include the day of discharge in the calculation unless the resident was discharged the same day as admitted. To make the calculations of the number of days a resident has stayed, you may wish to use the website, http://www.timeanddate.com/date/timeduration.html	
	(System Calculation) Average Length of Stay	
Transfers	How many residents have you transferred to a hospital (excluding deaths) during the reporting period? A resident, transferred to a hospital, is one expected to return to the assisted-care living facility, and a bed in the facility is held for the resident.	
Discharges (excluding deaths)	To Hospital (or transferred and did not return)	
	To Home (private residence)	
	To Residential Home for Aged	
	To Nursing Home	
	To Other Assisted-Care Living Facility	
	To All other	
	(System Calculation) Total	0
Payer type	How many resident days of care did you provide in the following categories? A resident day is a period of service between the census-taking hours on two successive calendar days. Count only the days of care provided during the reporting period. Report resident days according to the appropriate payment sources. For example, if a resident is admitted with a payment source of self pay and after 60 days is covered by long term care insurance, allocate 60 days to self pay and the remaining days to long term care insurance.	
	Self-Pay	
	Long-Term Care Insurance	
	Other 1, Specify	
	Other 2, Specify	
	(System Calculation) Total Resident Days of Care	0
	(System Calculation) Occupancy Rate	

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Schedule E - Utilization

Do not enter zero. Blank fields will represent zero residents.

		White		Black		Other		Total	
		Male	Female	Male	Female	Male	Female	Male	Female
Number of Residents served during this reporting period by Age, Gender and Race	Under 60 years							0	0
	60 to 64 years							0	0
	65 to 69 years							0	0
	70 to 74 years							0	0
	75 to 79 years							0	0
	80 to 84 years							0	0
	85 to 89 years							0	0
	90 to 94 years							0	0
	95 to 99 years							0	0
	Over 99 years							0	0
	(System Calculation) Total Residents by Gender	0	0	0	0	0	0	0	0
	(System Calculation) Total Residents by Race	0		0		0		0	

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Schedule E - Utilization

Do not enter zero. Blank fields will represent zero residents.

Resident Origin

Tennessee Counties

Please enter the number of residents from each county who received services during the reporting period.

County	Number of Residents	County	Number of Residents	County	Number of Residents
01 Anderson		33 Hamilton		65 Morgan	
02 Bedford		34 Hancock		66 Obion	
03 Benton		35 Hardeman		67 Overton	
04 Bledsoe		36 Hardin		68 Perry	
05 Blount		37 Hawkins		69 Pickett	
06 Bradley		38 Haywood		70 Polk	
07 Campbell		39 Henderson		71 Putnam	
08 Cannon		40 Henry		72 Rhea	
09 Carroll		41 Hickman		73 Roane	
10 Carter		42 Houston		74 Robertson	
11 Cheatham		43 Humphreys		75 Rutherford	
12 Chester		44 Jackson		76 Scott	
13 Claiborne		45 Jefferson		77 Sequatchie	
14 Clay		46 Johnson		78 Sevier	
15 Cocke		47 Knox		79 Shelby	
16 Coffee		48 Lake		80 Smith	
17 Crockett		49 Lauderdale		81 Stewart	
18 Cumberland		50 Lawrence		82 Sullivan	
19 Davidson		51 Lewis		83 Sumner	
20 Decatur		52 Lincoln		84 Tipton	
21 DeKalb		53 Loudon		85 Trousdale	
22 Dickson		54 McMinn		86 Unicoi	
23 Dyer		55 McNairy		87 Union	
24 Fayette		56 Macon		88 Van Buren	
25 Fentress		57 Madison		89 Warren	
26 Franklin		58 Marion		90 Washington	
27 Gibson		59 Marshall		91 Wayne	
28 Giles		60 Maury		92 Weakley	
29 Grainger		61 Meigs		93 White	
30 Greene		62 Monroe		94 Williamson	
31 Grundy		63 Montgomery		95 Wilson	
32 Hamblen		64 Moore		96 Unknown	
(System Calculation)			**Total Tennessee Residents:**		0

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Schedule E - Utilization

Do not enter zero. Blank fields will represent zero residents.

Resident Origin Out of State	01 Alabama		18 Kentucky		34 North Carolina	
	04 Arkansas		25 Mississippi		47 Virginia	
	11 Georgia		26 Missouri		55 Other States/ Countries	
	(System Calculation)		**Total Residents from Other States and Countries:**			0
	(System Calculation)		**Total Tennessee and Other States/Countries Residents:**			0

* Total Tennessee and Other States/Countries Residents should match Total number of Residents Served by Age, Gender, and Race section (Schedule E)

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Schedule F - Personnel

Please indicate the number of personnel on the last day of the reporting period. Leave the item blank if the value is unknown.
Full-time employees are those whose regularly scheduled workweek is usually 40 hours or more per week or at least 80 hours within a two week period.
Full Time Equivalent (FTE) = number of hours worked by part-time employees per week/40 hours per week, rounded to two decimal places. For example, three Registered Nurses, each working 20 hours a week, the FTE would be (3x20)/40=1.5. For two medical records employees, one working 10 hours per week and the other working 15 hours per week, the FTE would be (10+15)/40=.63.

Do not enter zero. Blank fields will represent zero employees.

	Type of Employee	Number of Employees		Employee Pool/ Consultant/Contract	
		Full-Time	Part-Time in FTE	Full-Time	Part-Time in FTE
Type of Employee by Service	Administrator				
	Assistant Administrators				
	Registered Nurses				
	Licensed Practical Nurses				
	Nurses Aides and Orderlies				
	Dietary Managers				
	Registered Dieticians				
	Dietetic Technicians				
	Medical Social Workers				
	Social Workers				
	Activity Coordinators				
	Maintenance				
	Housekeeping				
	Other (1), Specify:				
	Other (2), Specify:				
	Other (3), Specify:				
	Other (4), Specify:				
	(System Calculation) **Total:**	0	0.00	0	0.00

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Schedule F - Personnel

Please indicate below the number of personnel during the reporting period.

Do not enter zero. Blank fields will represent zero employees.

Please indicate the number of nursing personnel on duty on the last day of the reporting period (that is, on the premises and routinely serving the residents) for each shift. Do not include a person who is merely "on call."
Use the section for the three-shift pattern or for the two-shift pattern depending on your facility, or both if your facility uses a mix of 8 and 12 hours shifts.

Nursing Three Shifts per Day Patterns	Three Shifts	Shift # 1 (day)	Shift # 2 (evening)	Shift # 3 (night)	(System Calculation) Total
	Registered Nurses				0
	Licensed Practical Nurses				0
	Aides and/or Orderlies				0
	(System Calculation) Total	0	0	0	0

Nursing Two Shifts per Day Patterns	Two Shifts	Shift # 1 (day)	Shift # 2 (evening)		(System Calculation) Total
	Registered Nurses				0
	Licensed Practical Nurses				0
	Aides and/or Orderlies				0
	(System Calculation) Total	0	0		0

Benefits	Does your facility provide the following benefits? If you offer any of the listed benefits, report (yes) for that benefit whether or not you pay for all or any portion of the benefit for your employees.	401 K Plan	Yes/No	-
		Retirement Plan	Yes/No	-
		Health Insurance	Yes/No	-
		Life Insurance	Yes/No	-

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Schedule F - Personnel

Do not enter zero. Blank fields will represent zero employees.

	Nurse Type	Highest Education Level	FTE Number Currently Employed	Number of Budgeted Vacancies	Number of Positions Added in the Past 12 Months	Number of Positions Eliminated in the Past 12 Months
Nurses	Registered	Associate Degree				
		Diploma Nurse				
		Bachelors Degree				
		Masters Degree				
		Doctorate Degree				
		(System Calc) **Total**	0	0	0	0
	LPNs and Ancillary Nursing	LPN				
		Nurses Aides				
		(System Calc) **Total**	0	0	0	0

Contract Nursing Personnel	Yes/No	-	Does your organization use contract nursing personnel? If yes, indicate the number of contract personnel in the following categories in the past 12 months.

Type	Number of Contract Personnel	Number of Contract Budgeted Vacancies	Number of Contract Positions Added in the Past 12 Months	Number of Contract Positions Eliminated in the Past 12 Months
Registered Nurses				
Licensed Practical Nurses				
Certified Nurses Aides				
(System Calculation) **Total**	0	0	0	0

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Schedule G - Skilled Care Procedures

Procedures Provided	Please report the number of residents receiving the following procedures on the last day of the reporting period.		Number of Residents
	Medication	Given by intravenous injections	
		Given by intramuscular injections	
		Given by insulin pump	
	Intravenous Feeding	IV antibiotic therapy	
		IV chemotherapy	
	Tube Feedings	Gastrostomy: care of a surgical creation of an artificial opening into the stomach.	
		Jejunostomy: care of a surgical creation of a permanent opening between the jejunum and the surface of the abdominal wall.	
		Enteral nutrition: A form of nutrition that is delivered into the digestive system as a liquid. Drinking nutrition beverages or formulas and tube feeding are forms of enteral nutrition. Tube feeding can be used to add to what a person is able to eat or can be the only source of nutrition. A small feeding tube may be placed through the nose into the stomach or the small intestine, or it may be surgically placed into the stomach or the intestinal tract through an opening made on the outside of the abdomen, depending on how long it will be used.	
		Parenteral nutrition: A form of nutrition that is delivered into a vein. Parenteral nutrition does not use the digestive system. It may be given to people who are unable to absorb nutrients through the intestinal tract because of vomiting that won't stop, severe diarrhea, or intestinal disease. It may also be given to those undergoing high-dose chemotherapy or radiation and bone marrow transplantation. It is possible to give all of the protein, calories, vitamins and minerals a person needs using parenteral nutrition. Also known as hyper alimentation or total parenteral nutrition (TPN).	
	Respiratory Therapy	IPPB treatments: Intermittent Positive Pressure Breathing	
		Oxygen	
	Wound Care	Ducebitus Ulcer care: Care for an ulceration caused by prolonged pressure in a resident allowed to lie too still in bed for a long period of time; also called bed sore and pressure sore.	
		Sterile dressings with prescription medicine	
		Wound irrigations	
		Hemovac care	
		Diabetic wound care	
	Catheter Care	Hickman	
		Port-a-cath	
		Subclavian	

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Schedule G - Skilled Care Procedures

Procedures Provided	Please report the number of residents receiving the following procedures on the last day of the reporting period.		Number of Residents
	Enterostomy Care	Enterostomy: The formation of a permanent opening into the intestine through the abdominal wall; usually by surgical means; also, the opening so created.	
		Irrigation and care for a Colostomy (The surgical creation of an opening between the colon and the surface of the body; also used to refer to the opening, or stoma, so created)	
		Care for an Ileostomy (The surgical creation of an opening into the ileum, usually by establishing an ileal stoma on the abdominal wall)	
	Genital/ Urinary Care	Indwelling foley catheter maintenance and care	
		Intermittent bladder irrigations	
		Bladder irrigations, continuous with medication instillation	
	Therapy	Physical Therapy	
		Occupational Therapy	
		Speech Therapy	

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Schedule H - Activities of Daily Living (ADL)

Activities of Daily Living (ADLs)	ADLs	Number of residents on the last day of the reporting period that require assistance with activities of daily living (ADL) (Residents will be duplicated and should be counted in every category that applies.)	
		Bathing	
		Toileting	
		Dressing	
		Eating	
		Transferring (in and out of bed to chair)	
	Multiple ADLs	Number of residents on the last day of the reporting period by the number of ADLs requiring Assistance.	
		Require assistance with 1 ADL	
		Require assistance with 2 ADLs	
		Require assistance with 3 ADLs	
		Require assistance with 4 ADLs	
		Require assistance with 5 ADLs	
Instrumental Activities of Daily Living (IADLs)	IADLs	Number of residents on the last day of the reporting period that require assistance with instrumental activities of daily living (IADL) (Residents will be duplicated and should be counted in every category that applies.)	
		Money management	
		Shopping	
		Preparing meals	
		Using phones	
		Doing light housework	
		Taking medication	
	Multiple IADLs	Number of residents on the last day of the reporting period by the number of IADLs requiring assistance.	
		Require assistance with 1 IADL	
		Require assistance with 2 IALDs	
		Require assistance with 3 IALDs	
		Require assistance with 4 IADLs	
		Require assistance with 5 or more IADLs	

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Schedule I - Financial Data

Expenses	Type of Expenses (Exclude all depreciation and round figures to the nearest dollar)	Amount
	Administration: Include all expenses associated with administration in this item including payroll. Do not duplicate any administrative expenses in the other categories of expense.	
	Payroll: Include salaries for all full-time and part-time personnel.	
	Fringe Benefits: Social Security, group insurance, retirement benefit, etc.	
	Contract and Professional Fees.	
	Other Operating Expenses: Expenses for all energy expense (oil, natural gas, electricity, etc.), and all other operating expenses.	
	Non-operating Expenses: Expenses for interest, taxes (even though they are listed below), real estate lease expenses, and other non-operating expenses.	
	(System Calculation) **Total:**	$0
Taxes	Taxes (should also have been included in Expenses, above)	

Capital Assets			Cost	Market Value	Depreciation	
					Annual	Accumulated
Capital Assets	Building	Own or Lease -				
	Equipment	Own or Lease -				
	Other, Specify					
	(System Calculation) Total		$0	$0	$0	$0

Revenue from Charges	Revenue Source	Gross Resident Charges	Minus	Adjustment to Charges	Equals	Net Resident Revenue
	Self-Pay		-		=	$0
	Long-Term Care Insurance		-		=	$0
	Other		-		=	$0
	(System Calculation) Total	$0	-	$0	=	$0

Other Revenue	All Other Revenue	
Total Revenue	(System Calculation) Grand Total Revenue: Total Revenue from Charges plus All Other Revenue	$0

Detail of Adjustments to Charges	Bad Debt	
	Charity Care	
	Non-Government Contractual	
	Other	
	(System Calculation) Total Adjustments	$0

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Schedule I - Financial Data

Bad Debts	(1) Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future. (A) A debt must meet these criteria: (i) The provider must be able to establish that reasonable collection efforts were made. (ii) The debt was actually uncollectible when claimed as worthless. (iii) Sound business judgment established that there was no likelihood of recovery at any time in the future. (iv) Accounts turned over to a collection agency should be classified as bad debt. (B) If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than one hundred twenty (120) days from the date the first bill is mailed to the patient, the debt may be deemed uncollectible. Bankrupt accounts shall be considered bad debts, unless there is documented evidence that the medical bill caused bankruptcy. Such accounts would then be counted as charity.
Charity Care	(2) Charity care is reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. The provider should apply the following guidelines for making a determination of indigence or medical indigence: (A) The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence; (B) The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the patient's daily living), liabilities, and income and expenses. Indigence income means an amount not to exceed one hundred percent (100%) of the federal poverty guidelines. Medical indigence is a status reached when a person uses or commits all available current and expected resources to pay for medical bills and is not limited to a defined percent of the federal poverty guidelines. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence; (C) The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., Title XIX, local welfare agency and guardian; and (D) The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination. (E) Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the bad debt collection criteria.

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State ID:	000000	Facility Name:	-	2015
Administrator Declaration				
-	Have you Saved and Renamed the report with your State ID and Facility name as instructed? Example: "12345 ABC Assisted Living"			
-	Have you Checked and Corrected all Errors on the Error Tab?			
Administrator's Declaration	-	I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete.		
Date (mm/dd/yyyy) (use slashes)				